

CHILD INFORMATION GUIDE**TO BE FILLED OUT BY THE FOSTER PARENTS AT THE TIME THE FOSTER CHILD IS READY TO LEAVE YOUR HOME.**

As your foster child's caretaker you are often aware of the special things that the child is used to that makes him/her feel "at home." Please take a minute and share some of your "secrets" to help your foster child adjust faster to his/her new home. Answer the questions that apply to this child and leave the rest blank.

_____ has lived with me for _____ Age of child _____
 (Name of Child) (Length of Time)

YOUNGER CHILD

1. Eating:			
a) What time are meals served?			
b) When are snacks served?			
c) What kind of snacks are served?			
d) What foods does the child dislike? (or is allergic to?)			
e) What are the child's favorite foods?			

2. For Babies Only:			
a) What formula is used?			
b) How often does the baby eat?			
c) Any solid foods?			
d) Does the baby have any feeding problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:

3. Bathing:			
a) Is there a set time for bathing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when:
b) Does the child like a bath or a shower or both?	<input type="checkbox"/> Bath	<input type="checkbox"/> Shower	<input type="checkbox"/> Both
c) Any fears of water?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:

4. Bedtime:			
a) What time does the child go to bed and, if applicable, nap?	Bedtime:	Naptime:	
b) Is there a bedtime ritual (a bath, a story, a prayer)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
c) What kind of bed does the child sleep in?			
d) Who did the child sleep with in his/her room?			
e) Is a light left on?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
f) Does the child sleep with anything special (toy, pacifier, bottle, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
g) Does the child wake up at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Why?
h) Does the child wet the bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How is bed wetting handled?

5.	When the Child Needs Comfort:	
a)	What technique is the child accustomed to (kisses, hugs, back rub, etc.)?	
b)	How is the baby held (arms, shoulder)?	

6.	Discipline:	
a)	When discipline is needed, what works?	

Comments on some of the special problems you have had with the child.

OLDER CHILD

1.	Eating:		
a)	What is your family's meal schedule? What is the teen's meal routine?		
b)	Have you observed any symptoms of anorexia, bulimia, or hoarding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, explain:
c)	Any food allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, explain:
d)	What are the teen's food likes and dislikes?		
e)	Does teen show excessive preference for junk food?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, explain:
f)	Has sugar intake been monitored due to effects on behavior/ functioning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, explain:

2.	Personal Hygiene:		
a)	Is there a preference for	<input type="checkbox"/> Bath	<input type="checkbox"/> Shower
b)	If a girl, does she menstruate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No Any problems?
c)	If a boy, does he shave?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d)	Indicate teen's desire or requirements for special hygiene products.		
e)	Does teen require monitoring of hygiene care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, explain:

3.	Bed:		
a)	Is there a regular time for going to bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, indicate time:
b)	Has teen slept in a room alone or with others?	<input type="checkbox"/> Alone	<input type="checkbox"/> With others
c)	Are there any special needs (lights on, door open/shut, music, reading, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, explain:

4.	Behaviors:			
a)	Give brief description of teen's daily routine.			
b)	Any acting out? Describe. Frequency? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: If yes, frequency:			
c)	Any indications of sexual abuse, and/or any inappropriate sexual activity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
d)	Any lying or stealing? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give example:			
e)	Is teen abusive to others or animals? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
f)	Does teen date yet (single date, group date, keep a curfew)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
g)	How does teen handle peer relationships?			
h)	Does teen smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No			
i)	Have there been any examples of substance abuse (experimentation or problems) with drugs/alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			

5.	Hobbies:	
a)	Give brief description of teen's interest/ability for hobbies and/or sports.	
b)	Does teen show interest in school or church activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No

6.	School:		
a)	Any truancy problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b)	Indicate special interests.		
c)	Indicate overall attitude toward school (rules, authority and structured setting).		

Comments

Equal Opportunity Employer/Program

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